INSTRUCTIONS FOR THE INDIVIDUAL AND SERVICE LOCATION LIST PROVIDER VERIFICATION

Please review and correct the attached Individual and Service Location List - Provider Verification Forms so that they accurately reflect all of the individuals served at each location where services subject to certification are provided.

1. Please draw an "X" through any location on the list that no longer exists.

2. QE Site ID - This is the unique QE number for each location; do not verify/correct.

3. Service (Program Code and Description) - Correct/verify that it is the program code currently being used in the DMR purchase of service system. The current program codes are as follows:

3153 - Residential Services	3163 - Community Based Day Supports
3182 - Emergency Residence	3168 - Employment Supports
3177 – Individual Supports	3286 – Less than 24 hour residential supports

4. Location Name - Correct/verify only if this location has a name.

5. Location Address - Correct/verify the address.

   For **Placement Services** (Specialized Home Care), correct/verify that it is the corporate address - one "location" represents all placement services provided to individuals with mental retardation.

   For **Employment or Community Based Day Services**, if a location provides both Community Based Day Supports and Employment Supports, a unique QE Site ID will be assigned for individuals receiving Community Based Day Supports, and another unique QE Site ID will be assigned for individuals receiving Employment Supports. Both of these QE Site ID's will have the same Location Address, therefore, if a service has a name, please include it in the space provided.

   For **Residential Services** that are less than 24 hours, each location should be listed separately. Also, for **residential supports between 15 hours per week and 24 hours per day**, each location must be listed separately.

   For **Individual Support Services**, correct/verify that it is the corporate address – one "location" represents the Individual Support services.

6. QE Category - QE Category is a brief description of the service. Correct/verify the QE Category for the location. The following is a description of each QE Category:

   Category A - home providing 24 hour staffing supports; provider leases or owns the home.
   Category B - home providing 24 hour staffing supports; individual leases or owns the home.
   Category C - home providing less than 24 hour staffing supports; provider leases or owns the home.
   Category D - home providing less than 24 hour staffing supports; individual leases or owns the home.
   Category E - placement service (Specialized Home Care or Shared Living).
   Category F - site-based respite/emergency residence.
   Category G - employment or community based day supports.

Category I – Individual Supports Services

7. Capacity - correct/verify the maximum number of individuals who could be served at the location. For Placement Services and Individual Support services, put the maximum number of individuals served by your agency.

8. For each individual listed (include information about all individuals served, not exclusively individuals funded by DMR):
   a) It is not necessary to make any changes if the individual is currently receiving services at the location.
   b) If the individual no longer receives services at the location, write the date they left on the line provided (Date Left Location).
   c) If the individual was never served at the location, check the box next to the name (Never At Location).
   d) Additional lines have been provided to write in the names of individuals missing from the list, their social security numbers, and the dates they started in the service.

9. Some of the service locations that are currently operational may not have a location specific form in this packet. Blank forms at the end of the packet have been provided for your use in identifying these locations and the people served there. If your agency has a document that provides all the requested information for each of these locations, it may be attached to the packet instead of transferring the information to the report form.

10. Information helpful to obtaining a representative sample for **Site Based Respite.** Please list all Individuals served in site based respite over the past year and note the following for each:
    - Behavioral/psychiatric challenges
    - Complex medical needs

Thank you for your assistance in correcting and verifying this information!

DEPARTMENT OF MENTAL RETARDATION
OFFICE OF QUALITY ENHANCEMENT

APPLICATION FOR LICENSURE AND CERTIFICATION

(ALL RESPONSES MUST BE PRINTED OR TYPED.)

I. APPLICANT INFORMATION: Please complete or correct each section.

A. Applicant Name:

B. Federal Employer Identification Number (FEIN):

C. Office Address:

D. Executive Director

E. Office Telephone: **( )**

F. Provider Liaison: _____

G. DMR Regions where services are located: Central/West ___ North ___ South ___ Greater Boston ___

II. HAS THE APPLICANT EVER HAD A PROGRAM WHICH DMR OR ANY OTHER STATE AGENCY:

A. Refused to license or to renew licensure? Yes ___ No ___

B. Revoked? Yes ___ No ___

C. Suspended? Yes ___ No ___ Reinstated? Yes ___ No ___

D. Canceled or terminated contracts for cause? Yes ___ No ___

If "yes" to any of the above, attach a separate page listing name and address of program, original date of the license, action taken by DMR or other agency, date, and reason.

III. OTHER ACCREDITATION:

A. Has Applicant applied for a national accreditation? Yes ___ No ___
If no, go to Part IV. If yes, complete B - G.

B. Accrediting Organization: The Council _____ CARF _____ Other _____

C. For what specific services has the applicant applied for certification?

_____ _____ _____ _____ _____

D. Has agency received Accreditation? Yes ___ No ___
If yes, please attach Certificate or Letter of Accreditation and the most recent accreditation report.

E. Date of Accreditation: _____ Type: _____ Expiration Date: _____

F. Corrective Plan? Yes ___ No ___ If yes, please attach.

G. Does the applicant intend to use the accreditation process in lieu of DMR's certification review? ____ Yes ___ No

Application (continued)

IV. LICENSURE/CERTIFICATION REVIEW LIST:

A. For what services is the applicant applying for licensure?
___Residential
___Work/day supports
___Site based respite

B. For what services is the applicant applying for certification?
___Residential
___Work/day supports
___Site based respite
___Individual Supports

V. SERVICE LIST: (Only for services provided to individuals with mental retardation)

Attached is the QE Individual And Service Location List for your agency along with instructions for verifying and correcting the information. Once the verification is completed, please return it with the completed Application.

VI. LEGAL PROCEEDINGS:

Has the Applicant or any of its employees been a party to any lawsuit or hearing, or the subject of a criminal or civil investigation related to contracts or services which are funded by the Massachusetts Department of Mental Retardation or other governmental agency?

Yes ___ No ___

If yes, attach a separate page outlining the history, nature and disposition of the legal proceedings or investigation.

VII. AUTHORIZATION:

I certify, under the pains and penalties of perjury, that all the information contained herein is correct and complete. I will provide any information to the Department that may be required for certification.

_____
Date of Authorization

_____
Authorized Signature

_____
Type or Print Name

_____
Title

Attach copy of Applicant's governing body authorization for signatory to execute this Application for Certification.